

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF CLAIMS FOR MULTIPLE  
PROCEDURES PERFORMED IN THE  
SAME OPERATIVE SESSION IN  
AMBULATORY SURGICAL CENTERS**



**JANET REHNQUIST  
INSPECTOR GENERAL**

**DECEMBER 2002  
A-07-03-02655**

# ***Office of Inspector General***

<http://oig.hhs.gov/>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## ***Office of Audit Services***

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

## ***Office of Evaluation and Inspections***

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

## ***Office of Investigations***

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

## ***Office of Counsel to the Inspector General***

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.



Office of Audit Services  
Region VII  
601 East 12<sup>th</sup> Street, Room 284A  
Kansas City, MO 64106  
(816) 426-3591

CIN: A-07-03-02655  
December 5, 2002

Patricia Ainsley  
Vice President, Government Safeguards A/B  
First Coast Service Options, Inc.  
P.O. Box 2360  
Jacksonville, Florida 32231-0048

Dear Ms. Ainsley:

This report provides you with the results of our nationwide analysis entitled *Review of Claims for Multiple Procedures Performed in the Same Operative Session in Ambulatory Surgical Centers* (ASC). The objective of our analysis was to evaluate the effectiveness of carriers' claims processing systems in identifying payment reductions for multiple ASC procedures for calendar years 1997 through 2001. Nationwide, we identified 21,056 instances of overpayments totaling \$5,103,361, out of a total 54,549 (\$50,733,584) instances in which multiple ASC procedures performed during the same operative session were split between claims. First Coast Service Options, Inc.'s portion of the total overpayments was approximately \$374,907.

Regulations require that when multiple services are provided in the same operative session, the highest paying procedure is reimbursable at the full payment rate while the other procedures are reimbursable at one-half the normal payment rate. Our analysis showed that First Coast Service Options, Inc.'s systems failed to identify such instances, which resulted in provider overpayments for calendar years 1999 through 2001 of approximately \$112,979, \$121,123, and \$140,805 (\$374,907), respectively. Included in the identified overpayments is approximately \$75,124 in beneficiary overpayments for coinsurance. Most of the overpayments occurred because the carrier's processing system did not identify multiple procedures performed during the same session when submitted on separate claims.

We are recommending that First Coast Service Options, Inc.:

1. Recover the \$299,783 (\$374,907- \$75,124) in Medicare overpayments to ACSs;
2. Instruct ACSs to refund related coinsurance as required in 42 CFR 416.30, section C;

First Coast Service Options, Inc. generally agreed with our findings and recommendations. We have amended recommendation 1. to remove overpayments applicable to 1997 and 1998. We have also removed recommendations 3. and 4. because corrective action had been taken after we

had discussed our review with First Coast in 2001. First Coast's response, in its entirety, is attached to this report (see Appendix A).

## INTRODUCTION

### Background

An Ambulatory Surgical Center or ASC is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

To participate in the Medicare program as an independent ASC, a facility must meet the standards specified under section 1832(a)(2)(F)(I) of the Social Security Act (the Act) and 42 CFR 416.25. To be covered as an independent (distinct part) ASC operated by a hospital, a facility:

- Elects to do so, and continues to be covered unless CMS determines there is good cause to do otherwise;
- Is a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital with costs for the ASC treated as a non-reimbursable cost center on the hospital's cost report, and;
- Meets all the requirements with regard to health and safety, and agrees to the assignment, coverage and payment rules applied to independent ASCs.

Medicare payment for outpatient surgical procedures generally consists of two components: the cost of services furnished by the facility where the procedure is performed (the facility or technical component), and the cost of the physician's services for performing the procedure (the professional component). The facility component includes non-physician medical and other health services.

As specified under section 1833(i)(1)(A) of the Act, Medicare pays only for specific surgical procedures. The ASC accepts Medicare's payment for such procedures as payment in full with respect to those services defined as ASC facility services in HCFA Pub. 14, section 2265.2. Generally, covered ASC facility services are items and services furnished in connection with covered ASC surgical procedures. Covered ASC surgical procedures are listed in section 2266.2, Addendum A of the CMS Carriers Manual (HCFA Pub. 14). These procedures are classified into eight standard overhead amounts or payment groups, and payments to ASCs are made on the basis of prospectively set rates assigned to each payment group.

Regulations regarding Medicare payments for multiple surgical procedures performed in an ASC are contained in Title 42 Part 416.120 of the Code of Federal Regulations (42CFR416.120). According to 42CFR416.120, when one covered surgical procedure is furnished to a beneficiary in an operative session, payment is based on the prospectively determined rate for that procedure. When more than one surgical procedure is furnished in a single operative session, payment is based on the full rate for the procedure with the highest prospectively determined rate

and one half of the prospectively determined rate for each of the other procedures.

ASC facility services are subject to the Medicare Part B percent coinsurance and deductible requirements. Therefore, Medicare payment is 80 percent of the prospectively determined rate, adjusted for regional wage variations. The beneficiary's coinsurance amount is 20 percent of the assigned rate.

ASC facilities, under the *Terms of agreement with HCFA* (42CFR416.30, section C), agree to refund as promptly as possible any money incorrectly collected from beneficiaries or from someone on their behalf.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

The objective of this review was to determine whether the carriers' controls over processing ASC facility claims for multiple procedures performed in the same operative session are in accordance with Medicare rules and regulations.

### **Scope**

Our review was performed in accordance with Government Auditing Standards. Through a series of matching applications utilizing the nationwide Medicare Part B claims file processed by CMS for calendar years 1997 through 2001, we identified 54,549 instances in which multiple ASC procedures performed during the same operative session were split between claims. The associated claims, which served as the universe for our review, amounted to a total of \$50,733,584 in provider reimbursements, excluding deductible amounts. First Coast Service Options, Inc.'s portion of the total universe was \$8,429,050. Our review did not require an understanding or assessment of the complete internal control system.

### **Methodology**

A computer application used CMS's National Claims History file for calendar years 1997 through 2001 to identify beneficiary claims for the same operative session that did not indicate reductions for multiple surgeries. Preliminary results for 1997 through 1999 were forwarded to carriers in Missouri (Blue Cross & Blue Shield of Kansas and Missouri Medicare Services), California (National Heritage Insurance Co.), Florida (First Coast Service Options, Inc.), and Texas (Trail Blazer Health Enterprises, LLC) to verify that our analysis was correct.

We conducted our review during 2001 and 2002 at the Kansas City Regional Office, Kansas City, Missouri.

## **FINDINGS AND RECOMMENDATIONS**

### **Findings**

Our analysis of ASC facility charges for calendar years 1997 through 2001 indicates that carriers' control over processing claims for multiple ASC procedures performed in the same operative session are not in accordance with Medicare rules and regulations. Payments to ASC facilities for multiple surgeries performed in the same operative session were not being paid at the reduced rate.

Our review of ASC facility claims processed by First Coast Service Options, Inc. for calendar years 1997 through 2001 indicated overpayments in 1,944 out of 9,529 instances in which multiple procedures provided during the same operative session were split between claims. The dollar amount of overpayments was approximately \$470,482 out of approximately \$8,429,050 in provider reimbursements excluding deductible amounts. Included in the identified overpayments is approximately \$94,507 in beneficiary overpayments for coinsurance. Most of the overpayments occurred because the carrier's processing system did not identify multiple procedures performed during the same session when submitted on separate claims.

Computer applications used CMS's National Claims History file for calendar years 1997 through 2001 to identify beneficiary claims for the same operative session that did not indicate reductions for multiple surgeries for non-hospital based ASC facility services. Our analysis indicated the carriers' payment editors were not reducing the payments for multiple payments as required by 42CFR416.120. Preliminary results for 1997 through 1999 were forwarded to carriers in Missouri (Blue Cross & Blue Shield of Kansas and Missouri Medicare Services), California (National Heritage Insurance Co.), Florida (First Coast Service Options, Inc.), and Texas (Trail Blazer Health Enterprises, LLC) to verify that our analysis was correct.

Interviews with representatives for the five carriers mentioned above confirmed that program edits were not identifying all procedures subject to the rate reduction for multiple procedures performed during the same operative session when billed on separate claims. For example, beneficiary A has three multiple surgeries (in the same operative session) in ASC facility A. Facility A bills for two of the procedures on one claim. The carrier pays facility A the correct amount (the highest cost procedure is paid at 100 percent and the second procedure is paid at 50 percent of the rate), for the original claim. Facility A bills for the third procedure from the same operative session on a separate claim. Reimbursement for this procedure should also be reduced 50 percent. The carrier's payment editor did not recognize the procedure on the second processed claim as one of multiple procedures performed in the same session and therefore paid the claim at the full surgical rate. According to representatives for two of the carriers interviewed, in some instances the program editor suspended the claims for manual review, but the manual processor erroneously overrode the edit because of lack of training.

## Recommendations

We are recommending that First Coast Service Options, Inc.:

1. Recover the \$\$299,783 (\$374,907- \$75,124) in Medicare overpayments to ACSs;
2. Instruct ACSs to refund related coinsurance as required in 42 CFR 416.30, section C;

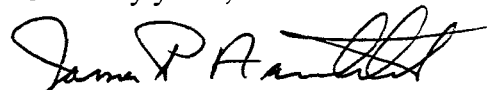
First Coast Service Options, Inc. generally agreed with our findings and recommendations. We have amended recommendation 1. to remove overpayments applicable to 1997 and 1998. We have also removed recommendations 3. and 4. because corrective action had been taken after we had discussed our review with First Coast in 2001. First Coast's response, in it's entirety, is attached to this report (see Appendix A).

\*\*\*\*\*

Final determinations as to actions taken on all matters will be made by the HHS official named below. We request you respond to the official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 522, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent information contained therein is not subject to exemptions of the ACT (see 45 CFR Part 5). As such, within ten business days after the final report is issued, it will be posted on the world-wide-web at <http://oig.hhs.gov/>.

Sincerely yours,



James P. Aasmundstad  
Regional Inspector General  
For Audit Services

Enclosure

HHS Action Official  
Rose Crum-Johnson  
Regional Administrator, Region IV  
Centers for Medicare and Medicaid Services  
Atlanta Federal Center  
61 Forsyth Street, S.W., Suite 4T20  
Atlanta, GA 30303-8909



A CMS CONTRACTED INTERMEDIARY & CARRIER

**MEDICARE**

Patricia M. Ainsley  
Vice President Program Safeguards  
First Coast Service Options, Inc.  
Pat.Ainsley@fcso.com

November 19, 2002

James P. Aasmundstad  
Regional Inspector General  
Office of Inspector General  
601 East 12<sup>th</sup> Street, Room 284A  
Kansas City, MO 64106

RE: CIN A-07-03-02655

Dear Mr. Aasmundstad:

The purpose of this letter is to respond to the findings and recommendations presented in your draft report concerning multiple procedures performed in the same operative session in Ambulatory Surgical Centers (ASCs). After researching the findings of this study, First Coast Service Options, Inc. agrees that there were issues with the claims auditing process on multiple ASC procedures split between claims in certain situations. Accordingly, our response to your recommendations is as follows:

1. Recover the \$375,975 (470,482 - \$94,507) in Medicare overpayments;

**Response:** We agree that overpayments should be recouped on the claims that were paid incorrectly. However, claims paid in calendar years 1997 and 1998 exceed the time limits allowed to collect overpayments according to the Medicare Carriers Manual, Part 3, Section 7100.1. Additionally, the amount of time to notify the ASCs of overpayments for claims paid in calendar year 1999 is limited (the ASCs must be notified by December 31, 2002) and will be operationally difficult.

2. Instruct ASCs to refund related coinsurance as required in 42CFR 416.30, Section C:

**Response:** We agree the ASCs should refund coinsurance to the affected beneficiaries; however, this would only apply in cases in which overpayments are recouped.



3. Identify and recoup all similar overpayments made between January 1, 2002 and the effective implementation of system changes to ensure that multiple procedures performed during the same operative session are paid properly.

**Response:** After receiving notice a study was being conducted on multiple procedures performed in ASCs in June 2001, FCSO initiated an assessment of the claims processing function relative to this subject. Our findings led us to correct a system problem on June 13, 2001 that had allowed the incorrect payments. Therefore, no overpayments should exist in calendar year 2002. Additionally, staff training was completed and an educational article was published concerning split billing.

4. Take necessary actions (such as edits, provider education, and/or carrier in-house training) to preclude such overpayments in the future.

**Response:** As described in response #3, actions were taken in June 2001 to correct the problem.

If you have any questions concerning these responses, please contact Robert Petty from my staff at (904) 791-6274.

Sincerely,

A handwritten signature in cursive script that reads "Lydia S. Rogers, for".

Patricia M. Ainsley